31A-28-101. Title.

This part is known as the "Utah Life and Health Insurance Guaranty Association Act."

Amended by Chapter 185, 2002 General Session

31A-28-102. Purpose.

(1) The purpose of this part is to protect, subject to certain limitations, the persons specified in Subsection 31A-28-103(1) against failure in the performance of contractual obligations, under a life and accident and health insurance policy or annuity contract specified in Subsection 31A-28-103(2), because of the impairment or insolvency of the member insurer that issued the policy or contract.

(2) To provide the protection described in Subsection (1):

(a) the Utah Life and Health Insurance Guaranty Association, which currently exists, is continued to pay benefits and to continue coverages as limited by this part; and

(b) members of the association are subject to assessment to provide funds to carry out the purpose of this part.

Amended by Chapter 116, 2001 General Session
Amended by Chapter 161, 2001 General Session

31A-28-103. Coverage and limitations.

(1) (a) This part provides coverage for a policy or contract specified in Subsection (2) to a person who is:

(i) a beneficiary, assignee, or payee of a person covered by Subsection (1)(a)(ii) regardless of where that person resides, except for a nonresident certificate holder under a group policy or contract; or

(ii) an owner of or a certificate holder under a policy or contract, other than an unallocated annuity contract or structured settlement annuity, if the owner or certificate holder is:

(A) a resident of Utah; or

(B) not a resident of Utah, but only if:

(I) the insurer that issued the policy or contract is domiciled in this state;

(II) the state in which the person resides has an association similar to the association created by this part; and

(III) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association's law.

(b) For an unallocated annuity contract specified in Subsection (2):

(i) Subsection (1)(a) does not apply; and

(ii) except as provided in Subsections (1)(d) and (1)(e), this part provides coverage for the unallocated annuity contract specified in Subsection (2) to a person who is:

(A) the owner of the unallocated annuity contract if the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of

business in this state; and

(B) an owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident.

(c) For a structured settlement annuity specified in Subsection (2):

(i) Subsection (1)(a) does not apply; and

(ii) except as provided in Subsections (1)(d) and (1)(e), this part provides coverage for the structured settlement annuity specified in Subsection (2) to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) is a resident, regardless of where the contract owner resides; or

(B) is not a resident, but only if one or more of the contract owners of the structured settlement annuity is a resident, or no contract owner of the structured settlement annuity is a resident, but:

(I) the insurer that issued the structured settlement annuity is domiciled in this state;

(II) the state in which the contract owner resides has an association similar to the association created by this part; and

(III) the payee, beneficiary, or the contract owner is not eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) This part may not provide coverage for a policy or contract specified in Subsection (2) to:

(i) a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

(ii) a person covered under Subsection (1)(b), if any coverage is provided to the person by the association of another state.

(e) (i) This part provides coverage for a policy or contract specified in Subsection (2) to a person who is a resident of this state and, in special circumstances, to a nonresident.

(ii) To avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person may not be provided coverage under this part.

(iii) In determining the application of this Subsection (1)(e) when a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one association.

(2) (a) (i) Except as limited by this part, this part provides coverage to a person specified in Subsection (1) for:

(A) a direct, nongroup life, accident and health, or annuity policy or contract;

(B) a supplemental contract to a policy or contract described in Subsection (2)(a)(i)(A);

(C) a certificate under a direct group policy or contract; and

(D) an unallocated annuity contract issued by a member insurer.

(ii) For purposes of Subsection (2)(a)(i), an annuity contract and a certificate under a group annuity contract includes:

(A) a guaranteed investment contract;

(B) a deposit administration contract;
(C) an unallocated funding agreement;
(D) an allocated funding agreement;
(E) a structured settlement annuity;
(F) an annuity issued to or in connection with a government lottery; and
(G) an immediate or deferred annuity contract.
(b) This part does not provide coverage for:
(i) a portion of a policy or contract:
(A) not guaranteed by the insurer; or
(B) under which the risk is borne by the policy or contract owner;
(ii) a policy or contract of reinsurance, unless:
(A) an assumption certificate is issued before the coverage date;
(B) the assumption certificate required by Subsection (2)(b)(ii)(A) is in effect pursuant to the reinsurance policy or contract; and
(C) the reinsurance contract is approved by the appropriate regulatory authorities;
(iii) a portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value, if the interest rate, crediting rate, or similar factor:
(A) is not excluded from coverage by Subsection (2)(b)(xi);
(B) averaged over the period of four years before the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged:
(I) for that same four-year period; or
(II) for the corresponding lesser period if the policy or contract was issued less than four years before the association became obligated; and
(C) exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available as determined on or after the earlier of the day on which the member insurer becomes:
(I) an impaired insurer under this part; or
(II) an insolvent insurer under this part;
(iv) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under:
(A) a multiple employer welfare arrangement as defined in 29 U.S.C. Sec. 1144;
(B) a minimum premium group insurance plan;
(C) a stop-loss group insurance plan; or
(D) an administrative services only contract;
(v) a portion of a policy or contract to the extent that it provides:
(A) a dividend;
(B) an experience rating credit;
(C) voting rights; or

(D) payment of a fee or allowance to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with respect to the benefit plan;

(vii) a portion of an unallocated annuity contract that is not issued to or in connection with:

(A) a specific benefit plan of:

(I) employees;

(II) a union; or

(III) an association of natural persons; or

(B) a government lottery;

(viii) a portion of a policy or contract to the extent that the assessment required by Section 31A-28-109 that applies to the policy or contract is preempted by federal or state law;

(ix) an obligation that does not arise under the express written terms of the policy or contract issued by an insurer to the contract owner or policy owner, including:

(A) a claim based on marketing materials;

(B) a claim based on a side letter, rider, or other document that is issued by the insurer without meeting applicable policy form filing or approval requirements;

(C) a misrepresentation regarding a policy benefit;

(D) an extra-contractual claim;

(E) a claim for penalties; or

(F) a claim for consequential or incidental damages;

(x) a contract that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by a person that is:

(A) (I) the benefit plan; or

(II) the benefit plan's trustee; and

(B) not an affiliate of the member insurer;

(xi) a portion of a policy or contract to the extent it provides for interest or other changes in value:

(A) to be determined by the use of an index or other external reference stated in the policy or contract; and

(B) (I) that have not been credited to the policy or contract; or

(II) as to which the policy or contract owner's rights are subject to forfeiture as of the date the member insurer becomes an impaired or insolvent insurer under this part; and

(xii) a policy providing hospital, medical, prescription drug, or other health care benefit pursuant to United States Code, Title 42, Subchapter XVIII, Chapter 7, Part C or D, or federal regulations issued under Part C or D.

(3) Subject to Subsection (4), the benefits for which the association may become liable may not exceed the lesser of:

(a) the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(b) with respect to one life, regardless of the number of policies or contracts:

(i) for a life insurance policy:

(A) if the insured died before the coverage date, $500,000 of the death benefit;

(B) if the insurer received a valid request for cash surrender before the coverage date but has not paid the cash surrender value before the coverage date, $200,000 of cash surrender benefits; or

(C) if neither Subsection (3)(b)(i)(A) nor (B) apply, the covered portion of each benefit provided under the policy;

(ii) for an annuity contract, the covered portion of each benefit provided under the contract;

(iii) for an accident and health policy:

(A) classified as health insurance, $500,000; or

(B) not classified as health insurance, the covered portion of each benefit provided under the policy;

(c) for an individual, or a beneficiary of that individual if the individual is deceased, participating in a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code, covered by an unallocated annuity contract, in the aggregate, $250,000 in present value of annuity benefits, including:

(i) net cash surrender; and

(ii) net cash withdrawal values; or

(d) for a payee of a structured settlement annuity or a beneficiary of the payee if the payee is deceased, the limits set forth in Subsection (3)(b).

(4) Notwithstanding Subsections (3)(a) through (d), the association may not be obligated to cover more than:

(a) an aggregate of $500,000 in benefits for any one life under:

(i) Subsection (3)(b)(i)(A);

(ii) Subsection (3)(b)(i)(B);

(iii) Subsection (3)(b)(ii); and

(iv) Subsection (3)(b)(iii)(B);

(b) $5,000,000 in benefits for one owner of multiple nongroup policies of life insurance:

(i) whether the policy owner is an individual, firm, corporation, or other person;

(ii) whether the persons insured are officers, managers, employees, or other persons; and

(iii) regardless of the number of policies and contracts held by the owner; and

(c) $5,000,000 in benefits, regardless of the number of contracts held by the contract owner or plan sponsor, for:

(i) one contract owner provided coverage under Subsection (1)(b)(ii)(B); or

(ii) one plan sponsor whose plans own, directly or in trust, one or more unallocated annuity contracts not included in Subsection (3)(b)(ii).

(5) (a) Notwithstanding Subsection (4)(c) and except as provided in Subsection (5)(b), the association shall provide coverage if one or more unallocated annuity contracts are:

(i) covered contracts under this part;

(ii) owned by a trust or other entity for the benefit of two or more plan sponsors; and

(iii) the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in the state.

(b) Notwithstanding Subsection (5)(a) the association may not be obligated to cover more than $5,000,000 in benefits with respect to the unallocated contracts described in Subsection (5)(a).

(6) (a) The limitations set forth in Subsections (3) and (4) are limitations on the benefits for which the association is obligated before taking into account:

(i) the association's subrogation and assignment rights; or

(ii) the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies.

(b) The costs of the association's obligations under this part may be met by the use of assets:

(i) attributable to covered policies, as described in Subsection 31A-28-114(3)(c); or

(ii) reimbursed to the association pursuant to the association's subrogation and assignment rights.

(c) On and after the date on which the association becomes obligated for a covered policy, the association may not be obligated to provide benefits to the extent that the benefits are based on an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value if the interest rate, crediting rate, or similar factor exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available on each date on which interest is credited or attributed to the covered policy.

(d) In performing its obligations to provide coverage under Section 31A-28-108, the association may not be required to guarantee, assume, reinsure, perform, or cause to be guaranteed, assumed, reinsured, or performed a contractual obligation of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract.

Amended by Chapter 292, 2010 General Session

31A-28-104. Construction.

This part shall be construed to effect the purposes under Section 31A-28-102.

Amended by Chapter 161, 2001 General Session

31A-28-105. Definitions.

As used in this part:

(1) "Association" means the Utah Life and Health Insurance Guaranty Association continued under Section 31A-28-106.

(2) (a) "Authorized assessment" or "authorized," when used in the context of assessments, means that the board of directors passed a resolution whereby an assessment will be called immediately or in the future from member insurers for an amount set forth in the resolution.

(b) An assessment is authorized when the resolution is passed.

(3) "Benefit plan" means a specific benefit plan of:

(a) employees;

(b) a union; or

(c) an association of natural persons.

(4) (a) "Called assessment" or "called," when used in the context of assessments, means that the association issued a notice to member insurers requiring that an authorized assessment be paid within the time frame set forth in the notice.

(b) All or part of an authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(5) "Cash surrender value" means the cash surrender value without reduction for an outstanding policy loan or surrender charge.

(6) "Contractual obligation" means an obligation under any of the following for which coverage is provided under Section 31A-28-103:

(a) a policy or contract;

(b) a certificate under a group policy or contract; or

(c) a portion of a policy or contract.

(7) "Coverage date" means the date on which the association becomes responsible for the obligations of a member insurer.

(8) "Covered policy" means any of the following for which coverage is provided in Section 31A-28-103:

(a) a policy or contract; or

(b) a portion of a policy or contract.

(9) (a) "Covered portion" means:

(i) for a covered policy that has a cash surrender value, a fraction calculated with:

(A) the numerator being the lesser of:

(I) (Aa) $200,000 for a life insurance policy; and

(Bb) $250,000 for a covered policy that is not a life insurance policy; or

(II) the cash surrender value of the policy; and

(B) the denominator being the cash surrender value of the policy; and

(ii) for a covered policy that does not have a cash surrender value, a fraction calculated with:

(A) the numerator being the lesser of:

(I) (Aa) $200,000 for a life insurance policy; or

(Bb) $250,000 for a covered policy that is not a life insurance policy; or

(II) the policy's minimum statutory reserve; and

(B) the denominator being the policy's minimum statutory reserve.

(b) The cash surrender value and the minimum statutory reserve are determined as of the coverage date in accordance with the exclusions in Subsection 31A-28-103(2)(b)(iii).

(10) "Extra-contractual claim" includes a claim relating to:

(a) bad faith in the payment of a claim;

(b) punitive or exemplary damages; or

(c) attorney fees and costs.

(11) "Impaired insurer" means a member insurer that is not an insolvent insurer and:

(a) is considered by the commissioner to be hazardous pursuant to this title; or

(b) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(12) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(13) (a) "Member insurer" means an insurer that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 31A-28-103.

(b) "Member insurer" includes an insurer whose license or certificate of authority in this state may have been:

(i) suspended;

(ii) revoked;

(iii) not renewed; or

(iv) voluntarily withdrawn.

(c) "Member insurer" does not include:

(i) a for-profit or nonprofit:

(A) hospital;

(B) hospital service organization; or

(C) medical service organization;

(ii) a health maintenance organization;

(iii) a fraternal benefit society;

(iv) a mandatory state pooling plan;

(v) a mutual assessment company or other person that operates on an assessment basis;

(vi) an insurance exchange;

(vii) an organization described in Subsection 31A-22-1305(2); or

(viii) an entity similar to an entity described in Subsections (13)(c)(i) through (vii).

(14) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor to Moody's Investors Service, Inc.

(15) (a) "Owner" of a policy or contract, "policy owner," or "contract owner" means a person who:

(i) is identified as the legal owner under the terms of the policy or contract; or

(ii) is otherwise vested with legal title to the policy or contract through a valid assignment:

(A) completed in accordance with the terms of the policy or contract; and

(B) properly recorded as the owner on the books of the insurer.

(b) "Owner," "policy owner," or "contract owner" does not include a person with only a beneficial interest in a policy or contract.

(16) "Person" means:

(a) an individual;

(b) a corporation;

(c) a limited liability company;

(d) a partnership;

(e) an association;

(f) a governmental body or entity;

(g) a trust; or

(h) a voluntary organization.

(17) "Plan sponsor" means:

(a) the employer, in the case of a benefit plan established or maintained by a single employer;

(b) the employee organization, in the case of a benefit plan established or maintained by an employee organization; or

(c) the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain a benefit plan, in the case of a benefit plan established or maintained by:

(i) two or more employers; or

(ii) jointly by:

(A) one or more employers; and

(B) one or more employee organizations.

(18) (a) "Premiums" means an amount or consideration received on covered policies or contracts, less:

(i) returned:

(A) premiums;

(B) considerations; and

(C) deposits; and

(ii) dividends and experience credits.

(b) (i) "Premiums" does not include an amount or consideration received for:

(A) a policy or contract for which coverage is not provided under Subsection 31A-28-103(2); or

(B) the portion of a policy or contract for which coverage is not provided under Subsection 31A-28-103(2).

(ii) Notwithstanding Subsection (18)(b)(i), an assessable premium may not be reduced on account of:

(A) Subsection 31A-28-103(2)(b)(iii) relating to interest limitations; and

(B) Subsection 31A-28-103(3) relating to limitations for:

(I) one individual;

(II) any one participant; and

(III) any one contract owner.

(c) "Premiums" does not include premiums in excess of $5,000,000:

(i) on an unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code; or

(ii) for multiple nongroup policies of life insurance owned by one owner:

(A) whether the policy owner is an individual, firm, corporation, or other person;

(B) whether the persons insured are officers, managers, employees, or other persons; and

(C) regardless of the number of policies or contracts held by the owner.

(19) (a) Except as provided in Subsection (19)(b), "principal place of business" of a plan sponsor or a person other than a natural person means the single state:

(i) in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise the

function; and

(ii) determined by the association in its reasonable judgment by considering the following factors:

(A) the state in which the primary executive and administrative headquarters of the entity are located;

(B) the state in which the principal office of the chief executive officer of the entity is located;

(C) the state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(D) the state in which the executive or management committee of the board of directors, or similar governing person, of the entity conducts the majority of its meetings;

(E) the state from which the management of the overall operations of the entity is directed; and

(F) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors described in Subsections (19)(a)(ii)(A) through (E).

(b) Notwithstanding Subsection (19)(a), in the case of a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, the state where more than 50% of the participants are employed is considered to be the principal place of business of the plan sponsor.

(c) (i) The principal place of business of a plan sponsor of a benefit plan described in Subsection (3) is considered to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(ii) If for a benefit plan described in Subsection (3) there is not a specific or clear designation of a principal place of business under Subsection (19)(c)(i), the principal place of business is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan.

(20) "Receiver" means, as the context requires:

(a) a rehabilitator;

(b) a liquidator;

(c) an ancillary receiver; or

(d) a conservator.

(21) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(22) (a) "Resident" means a person:

(i) to whom a contractual obligation is owed; and

(ii) who resides in this state on the earlier of the date a member insurer is an:

(A) impaired insurer; or

(B) insolvent insurer.

(b) A person may be a resident of only one state, which in the case of a person other than a natural person is where its principal place of business is located.

(c) A citizen of the United States that is either a resident of a foreign country or a

resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this part, is considered a resident of the state of domicile of the insurer that issued the policy or contract.

(23) "State" means:

(a) a state;

(b) the District of Columbia;

(c) Puerto Rico; and

(d) a United States possession, territory, or protectorate.

(24) "Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for personal injury suffered by the plaintiff or other claimant.

(25) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a policy or contract for:

(a) life;

(b) accident and health; or

(c) annuity.

(26) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Amended by Chapter 292, 2010 General Session

31A-28-106. Continuation of the association -- Association duties -- Allocation of assessments -- Not agency of state.

(1) (a) There is continued under this part the nonprofit legal entity known as the Utah Life and Health Insurance Guaranty Association created under former provisions of this title.

(b) All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state.

(c) The association shall:

(i) perform its functions under the plan of operation established and approved under Section 31A-28-110; and

(ii) exercise its powers through a board of directors established under Section 31A-28-107.

(d) The association shall allocate assessments among the following classes or subclasses:

(i) the life insurance and annuity class, which includes the following subclasses:

(A) the life insurance subclass;

(B) the annuity subclass:

(I) which includes annuity contracts owned by a governmental retirement plan, or its trustee, established under Section 401, 403(b), or 457, Internal Revenue Code; and

(II) otherwise excludes unallocated annuities; and

(C) the unallocated annuity subclass, which excludes contracts owned by a governmental retirement benefit plan, or its trustee, established under Sections 401,

403(b), or 457, Internal Revenue Code; and

(ii) the accident and health insurance class.

(2) (a) The association shall:

(i) come under the immediate supervision of the commissioner; and

(ii) be subject to the applicable provisions of the insurance laws of this state.

(b) Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

(3) The association is not an agency of the state.

Amended by Chapter 320, 2006 General Session

31A-28-107. Board of directors.

(1) (a) The board of directors of the association shall consist of:

(i) at least five but not more than nine member insurers who:

(A) subject to Subsection (1)(e), serve terms as established in the plan of operation; and

(B) are selected by member insurers, subject to the approval of the commissioner; and

(ii) two public representatives appointed by the commissioner.

(b) (i) The commissioner shall make the appointment of a public representative coincide with the association's annual meeting at which the association's board of directors is elected.

(ii) A public representative may not be:

(A) an officer, director, or employee of an insurer; or

(B) a person engaged in the business of insurance.

(iii) Subject to Subsection (1)(e), a public representative shall serve a term of three years.

(c) When a vacancy occurs in the membership of the board of directors for any reason:

(i) if the vacancy is of a member insurer, a replacement may be elected for the unexpired term by a majority vote of the remaining board members, subject to the approval of the commissioner; and

(ii) if the vacancy is of a public representative, the commissioner shall appoint a replacement for the unexpired term.

(d) In approving a selection or in appointing a member to the board of directors, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(e) Notwithstanding Subsections (1)(a) and (b), the commissioner shall, at the time of election, reelection, appointment, or reappointment adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board of directors is selected during any two-year period.

(2) (a) A member of the board of directors may be reimbursed from the assets of the association for expenses incurred by the member as a member of the board of directors.

(b) A public representative appointed under Subsection (1)(a)(ii) may not receive compensation or benefits for the public representative's service, but in addition to

reimbursement under Subsection (2)(a), a public representative may receive per diem and travel expenses established by the board with the approval of the commissioner.

(c) Except as provided in Subsections (2)(a) and (b), a member of the board of directors may not be compensated by the association for the member's services.

Amended by Chapter 284, 2011 General Session

31A-28-108. Powers and duties of the association.

(1) (a) If a member insurer is an impaired insurer, subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, the association may provide the protections provided by this part.

(b) If the association makes the election described in Subsection (1)(a), the association may proceed under one or more of the options described in Subsection (3).

(2) If a member insurer is an insolvent insurer, the association shall provide the protections provided by this part by electing in its discretion to proceed under one or more of the options in Subsection (3).

(3) With respect to the covered portions of covered policies of an impaired or insolvent insurer, the association may:

(a) (i) (A) guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insurer; or

(B) assure payment of the contractual obligations of the insolvent insurer; and

(ii) provide the money, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(b) provide benefits and coverages in accordance with Subsection (4).

(4) (a) In accordance with Subsection (3)(b), the association may:

(i) assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insurer, for claims incurred:

(A) with respect to group policies:

(I) not later than the earlier of the next renewal date under the policies or contracts or 45 days after the coverage date; and

(II) in no event less than 30 days after the coverage date; or

(B) with respect to nongroup policies or contracts:

(I) not later than the earlier of the next renewal date, if any, under the policies or contracts or one year from the coverage date; and

(II) in no event less than 30 days from the coverage date;

(ii) make diligent efforts to notify the following 30 days before any termination of the benefits that are provided under a policy or contract of the insurer:

(A) the known insureds or annuitants for nongroup policies and contracts;

(B) owners if other than an insured or annuitant; or

(C) group policy owners for group policies and contracts; and

(iii) with respect to nongroup life and accident and health insurance policies and annuities, make available substitute coverage on an individual basis, in accordance with Subsection (4)(b), to each known insured, annuitant, or owner and to each individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage on an individual basis in accordance with Subsection

(4)(b), if the insured or annuitant had a right under law or the terminated policy or annuity contract to:

(A) convert coverage to individual coverage; or

(B) continue an individual policy in force until a specified age or for a specified time during which the insurer had:

(I) no right unilaterally to make changes in any provision of the policy; or

(II) a right only to make changes in premium by class.

(b) (i) In providing the substitute coverage required under Subsection (4)(a)(iii), the association may offer to:

(A) reissue the terminated coverage; or

(B) issue an alternative policy.

(ii) An alternative or reissued policy under Subsection (4)(b)(i):

(A) shall be offered without requiring evidence of insurability; and

(B) may not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(iii) The association may reinsure an alternative or reissued policy.

(c) (i) An alternative policy adopted by the association is subject to the approval of the commissioner.

(ii) The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(iii) An alternative policy:

(A) shall contain at least the minimum statutory provisions required in this state; and

(B) provide benefits that are not unreasonable in relation to the premium charged.

(iv) The association shall set the premium for an alternative policy in accordance with a table of rates that the association adopts. The premium shall reflect:

(A) the amount of insurance to be provided; and

(B) the age and class of risk of each insured.

(v) For an alternative policy issued under an individual policy of the impaired or insolvent insurer:

(A) age shall be determined in accordance with the original policy provisions; and

(B) class of risk is the class of risk under the original policy.

(vi) For an alternative policy issued to individuals insured under a group policy:

(A) age and class of risk shall be determined by the association in accordance with the alternative policy provisions and risk classification standards approved by the commissioner; and

(B) the premium may not reflect any changes in the health of the insured after the original policy was last underwritten.

(vii) An alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(d) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the association shall set the premium in accordance with the amount of insurance provided and the age and class of

risk, subject to the approval of the commissioner or by a court of competent jurisdiction.

(e) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy ceases on the date the coverage or policy is replaced by another similar policy by:

(i) the owner;

(ii) the insured; or

(iii) the association.

(f) (i) With respect to a claim unpaid as of the coverage date and a claim incurred during the period defined in Subsection (4)(a)(i), a provider of health care services, by accepting a payment from the association upon a claim of the provider against an insured whose health care insurer is an insolvent member insurer, agrees to forgive the insured of 20% of the debt which otherwise would be paid by the insurer had it not been insolvent, subject to a maximum of $8,000 being required to be forgiven by any one provider as to each claimant.

(ii) The obligations of a solvent insurer to pay all or part of the covered claim are not diminished by the forgiveness provided for in this section.

(5) When proceeding under Subsection (3)(b) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Subsection 31A-28-103(2)(b)(iii).

(6) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with this part.

(7) (a) Premium due after the coverage date with respect to the covered portion of a policy or contract of an impaired or insolvent insurer belongs to and is payable at the direction of the association. If a liquidator of an insolvent insurer requests the report, the association shall report to the liquidator the premium collected by the association.

(b) The association is liable to a policy or contract owner for unearned premiums due to the policy or contract owner arising after the coverage date with respect to the covered portion of the policy or contract.

(8) The protection provided by this part does not apply if any guaranty protection is provided to residents of this state by laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(9) In carrying out its duties under Subsection (2), and subject to approval by a court in this state, the association may:

(a) impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that:

(i) the amounts that can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part; or

(ii) the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens to

be in the public interest;

(b) impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value; and

(c) if the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure:

(i) established by the receiver; and

(ii) approved by the receivership court.

(10) (a) A special deposit in this state held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in any state shall be promptly paid to the association.

(b) Any amount paid under Subsection (10)(a) to the association less the amount retained by the association shall be treated as a distribution of estate assets pursuant to Sections 31A-27a-601, 31A-27a-602, and 31A-27a-701.

(11) If the association fails to act within a reasonable period of time as provided in this section, the commissioner has the powers and duties of the association under this part with respect to an impaired or insolvent insurer.

(12) The association may assist or advise the commissioner, upon the commissioner's request, concerning:

(a) rehabilitation;

(b) payment of claims;

(c) continuance of coverage; or

(d) the performance of other contractual obligations of any impaired or insolvent insurer.

(13) (a) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over:

(i) an impaired or insolvent insurer concerning which the association is or may become obligated under this part; or

(ii) any person or property against which the association may have rights through subrogation or otherwise.

(b) The standing referred to in Subsection (13)(a) extends to all matters germane to the powers and duties of the association, including:

(i) proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer; and

(ii) the determination of the policies or contracts and contractual obligations.

(c) The association has the right to appear or intervene before a court in another state with jurisdiction over:

(i) an impaired or insolvent insurer for which the association is or may become

obligated; or

(ii) any person or property against which the association may have rights through subrogation of the insurer's policyowners.

(14) (a) A person receiving benefits under this part is considered to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of, or on account of:

(i) contractual obligations;

(ii) continuation of coverage; or

(iii) provision of substitute or alternative coverages.

(b) As a condition precedent to the receipt of any right or benefits conferred by this part upon that person, the association may require an assignment to it of the rights and causes of action described in Subsection (14)(a) by any:

(i) payee;

(ii) policy or contract owner;

(iii) beneficiary;

(iv) insured; or

(v) annuitant.

(c) The subrogation rights obtained by the association under this Subsection (14) have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.

(d) In addition to Subsections (14)(a) through (c), the association has the common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including in the case of a structured settlement annuity any rights of the owner, beneficiary, or payee of the annuity to the extent of benefits received pursuant to this part against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment of the annuity.

(e) If a provision of this Subsection (14) is invalid or ineffective with respect to a person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion of the policies, covered by the association.

(f) If the association has provided benefits with respect to a covered policy and a person recovers amounts as to which the association has rights as described in this Subsection (14), the person shall pay to the association the portion of the recovery attributable to the covered policies.

(15) (a) In addition to the rights and powers elsewhere in this part, the association may:

(i) enter into a contract that is necessary or proper to carry out the provisions and purposes of this part;

(ii) sue or be sued, including taking any legal actions necessary or proper to:

(A) recover any unpaid assessments under Section 31A-28-109; and

(B) settle claims or potential claims against the association;

(iii) borrow money to effect the purposes of this part;

(iv) employ or retain the persons necessary or the appropriate staff members to:

(A) handle the financial transactions of the association; and

(B) perform other functions as become necessary or proper under this part;

(v) take necessary or appropriate legal action to avoid or recover payment of improper claims;

(vi) exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligation under this part;

(vii) request information from a person seeking coverage from the association to aid the association in determining the association's obligations under this part with respect to the person;

(viii) take other necessary or appropriate action to discharge the association's duties and obligations under this part or to exercise the association's powers under this part; and

(ix) act as a special deputy receiver if appointed by the commissioner.

(b) Any note or other evidence of indebtedness of the association under Subsection (15)(a)(iii) that is not in default:

(i) is a legal investment for a domestic insurer; and

(ii) may be carried as admitted assets.

(c) A person seeking coverage from the association shall promptly comply with a request for information by the association under Subsection (15)(a)(vii).

(16) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(17) (a) At any time within 180 days after the coverage date, the association may elect to succeed to the rights and obligations of the member insurer that:

(i) accrue on or after the coverage date; and

(ii) relate to covered policies under any one or more indemnity reinsurance agreements:

(A) entered into by the member insurer as a ceding insurer and its reinsurer; and

(B) selected by the association.

(b) An election made pursuant to Subsection (17)(a) is effective as of the date of the order of liquidation.

(c) The association may make an election described in Subsection (17)(a) by notifying an affected reinsurer in writing, with verification of receipt, through:

(i) the association; or

(ii) a nationally recognized association representing state guaranty associations that is approved by the commissioner, that provides notice on behalf of the association.

(d) The association shall provide a copy of the notice described in Subsection (17)(c) to the receiver.

(e) (i) The receiver of an insolvent insurer and each reinsurer of the ceding member insurers shall make available as soon as possible after commencement of formal delinquency proceedings the information described in Subsection (17)(e)(ii) to:

(A) the association; or

(B) a nationally recognized association representing state guaranty associations that is approved by the commissioner, on behalf of the association.

(ii) This Subsection (17)(e) applies to:

(A) copies of in-force contracts of reinsurance and the related records relevant to the determination of whether the in-force contracts of reinsurance should be assumed;

(B) notices of any default under a reinsurance contract; or

(C) any known event or condition that with the passage of time could become a default under a reinsurance contract.

(f) If the association makes an election under Subsection (17)(a), the association shall comply with Subsections (17)(f)(i) through (vii) with respect to the agreements selected by the association.

(i) For a contract covered, in whole or in part, by the association, the association is responsible for:

(A) the unpaid premiums due under the agreements for periods both before and after the coverage date; and

(B) the performance of the other obligations to be performed after the coverage date.

(ii) The association may charge a contract covered in part by the association the costs for reinsurance in excess of the obligations of the association, through reasonable allocation methods.

(iii) The association shall provide notice and an accounting to the receiver of a charge made pursuant to Subsection (17)(f)(ii).

(iv) The association is entitled to any amounts payable by the reinsurer under the agreements with respect to a loss or event that:

(A) occurs after the coverage date; and

(B) relates to a contract covered by the association, in whole or in part.

(v) On receipt of any amounts under Subsection (17)(f)(iv), the association shall pay to the beneficiary under the policy or contract on account of which the amounts were paid an amount equal to the lesser of:

(A) the amount received by the association; and

(B) the excess of the amount received by the association over the benefits paid or payable by the association on account of the policy or contract less the retention of the insurer applicable to the loss or event.

(vi) (A) Within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to the items paid by either the member insurer, its receiver, or the indemnity reinsurer before the date of the association's election.

(B) Within five days of the completion of the calculation under Subsection (17)(f)(vi)(A):

(I) the reinsurer shall pay the receiver the amounts due for a loss or event before the coverage date, subject to any set-off for premiums unpaid for a period before the coverage date; and

(II) the association or the reinsurer shall pay any remaining balance due the other.

(C) A dispute over an amount due to either party shall be resolved:

(I) by arbitration pursuant to the terms of the affected reinsurance contract; or

(II) if the reinsurance contract contains no arbitration clause, as otherwise provided by law.

(D) If the receiver receives an amount due the association pursuant to Subsection (17)(f)(iv), the receiver shall remit that amount to the association as promptly as practicable.

(vii) If the association, or the receiver on behalf of the association, within 60 days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer may not:

(A) terminate the reinsurance agreement for failure to pay premium, to the extent the reinsurance agreement relates to a policy or contract covered by the association, in whole or in part; and

(B) set off against amounts due the association an amount due:

(I) under another contract; or

(II) as an unpaid amount due from a person other than the association.

(g) (i) This Subsection (17)(g) applies during the period that:

(A) begins on the coverage date; and

(B) ends:

(I) on the election date; or

(II) if no election date occurs, 180 days after the coverage date.

(ii) During the period described in Subsection (17)(g)(i):

(A) neither the association nor the reinsurer have a right or obligation under a reinsurance contract that the association may assume under Subsection (17)(a), whether for a period before or after the coverage date; and

(B) the reinsurer, the receiver, and the association, to the extent practicable, shall provide each other data and records reasonably requested.

(iii) Notwithstanding Subsection (17)(g)(ii), once the association elects to assume a reinsurance contract, the parties' rights and obligations are governed by Subsections (17)(f)(i) through (vi).

(h) If the association does not elect to assume a reinsurance contract by the election date pursuant to Subsection (17)(a), the association has no right or obligation with respect to the reinsurance contract, whether for a period before or after the coverage date.

(i) An insurer other than the association succeeds to the rights and obligations of the association under Subsections (17)(a) through (f) effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in Subsections (17)(a) through (f) provided that:

(i) the association transfers its obligations to the other insurer;

(ii) the association and the other insurer agree to the transfer;

(iii) the indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(iv) the obligations described in Subsection (17)(f)(v) may not apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer;

(v) the transferring party shall give notice in writing, with verification of receipt, to

the affected reinsurer not less than 30 days before the effective date of the transfer; and

(vi) this Subsection (17)(i) may not apply if the association has previously expressly determined in writing that the association will not exercise the election referred to in Subsections (17)(a) through (f).

(j) (i) This Subsection (17) supersedes the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the coverage date, to:

(A) the receiver of an insolvent member insurer; or

(B) another person.

(ii) The receiver is entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to a loss or event that occurs before the coverage date, subject to applicable setoff provisions.

(k) Except as otherwise expressly provided in Subsections (17)(a) through (j), this Subsection (17) does not:

(i) alter or modify the terms and conditions of a reinsurance agreement of the insolvent member insurer;

(ii) abrogate or limit a right any reinsurer to claim that it is entitled to rescind a reinsurance agreement;

(iii) give a policy owner or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance agreement;

(iv) limit or affect the association's rights as a creditor of the estate of an insolvent insurer against the assets of the estate; or

(v) apply to a reinsurance agreement that covers property or casualty risks.

(18) The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(19) If the association arranges or offers to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(20) (a) Venue in a suit against the association arising under this part is Salt Lake County.

(b) The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

Amended by Chapter 292, 2010 General Session

31A-28-109. Assessments.

(1) (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each class or subclass, at the time and for the amounts that the board of directors finds necessary.

(b) Member insurer liability for an assessment is established as of the coverage date.

(c) Subject to Subsection (1)(d), a called assessment:

(i) is due not less than 30 days after prior written notice to the member insurer; and

(ii) shall accrue interest at 10% per annum on and after the due date.

(d) Notwithstanding Subsection (1)(c), the association may:

(i) assess the association's members as of the coverage date; and

(ii) defer the collection of the assessment described in Subsection (1)(d)(i).

(e) An assessment:

(i) has the force and effect of a judgment lien against the member insurer; and

(ii) may not be extinguished until paid.

(2) The two classes of assessment are described in Subsections (2)(a) and (2)(b).

(a) A Class A assessment shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. A Class A assessment may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) A Class B assessment shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 31A-28-108 with regard to an impaired or an insolvent insurer.

(3) (a) (i) The amount of a Class A assessment:

(A) shall be determined by the board of directors; and

(B) may be authorized and called on a pro rata or non-pro rata basis.

(ii) If the Class A assessment is pro rata, the board of directors may credit the assessment against future Class B assessments.

(iii) The total of the non-pro rata assessments may not exceed $300 per member insurer in any one calendar year.

(b) The amount of a Class B assessment shall be allocated for assessment purposes among subclasses pursuant to an allocation formula that may be based on:

(i) the premiums or reserves of the impaired or insolvent insurer; or

(ii) any other standard determined by the board of directors in the board of directors' sole discretion as being fair and reasonable under the circumstances.

(c) (i) A Class B assessment against a member insurer for the life insurance subclass, the annuity subclass, and the unallocated annuity subclass shall be in the proportion that the premiums received on business in this state by the member insurer on policies or contracts included in the subclass for the three most recent calendar years for which information is available preceding the year which includes the coverage date bears to the premiums received on business in this state for the same period by the assessed member insurers.

(ii) A Class B assessment against a member insurer for an accident and health insurance subclass shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts included in the subclass for the most recent calendar year for which information is available preceding the year in which the assessment is made bears to the premiums received on business in this state on policies or contracts included in the subclass for that calendar year by the assessed member insurers.

(d) Assessments for funds to meet the requirements of the association with

respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this part.

(e) Classification of assessments and premiums under Subsection (3)(b) and computation of assessments under this Subsection (3) shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(f) The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the day on which the assessment is authorized.

(4) (a) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations.

(b) If an assessment against a member insurer is abated or deferred in whole or in part under Subsection (4)(a), the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(c) Once a condition that caused a deferral is removed or rectified, the member insurer shall pay the assessments that were deferred pursuant to a repayment plan approved by the association.

(5) (a) (i) Subject to Subsection (5)(b), the total of the assessments authorized by the association on a member insurer for each subclass may not in any one calendar year exceed 2% of that member's total average annual assessable premium in that subclass as defined in Subsection (3).

(ii) If two or more assessments are authorized in one calendar year with respect to one or more insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation in Subsection (5)(a)(i) shall be equal and limited to the highest of the total average annual assessable premiums of the different calendar year periods involved in the assessment or assessments.

(iii) If the maximum assessment together with the other assets of the association do not provide in one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon after as permitted by this part.

(b) The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If the maximum assessment for the life insurance or annuity subclass in any one year does not provide an amount sufficient to carry out the responsibilities of the association, the board of directors shall assess the other of the subclasses of the life insurance and annuity class for the necessary additional amount:

(i) pursuant to Subsection (3)(b); and

(ii) subject to the maximum stated in Subsection (5)(a).

(6) (a) The board of directors may, by an equitable method established in the plan of operation, refund to member insurers in proportion to the contribution of each insurer to that subclass the amount by which the assets of the subclass exceed the amount the board of directors finds is necessary to carry out the obligations of the

association with regard to that subclass, including assets accruing from:

(i) assignment;

(ii) subrogation;

(iii) net realized gains; and

(iv) income from investments.

(b) Notwithstanding Subsection (6)(a), a reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

(7) A member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, may consider the amount reasonably necessary to meet its assessment obligations under this part.

(8) (a) The association shall issue to each insurer paying an assessment under this part, other than a Class A assessment, a certificate of contribution, in a form approved by the commissioner, for the amount of the assessment paid.

(b) The outstanding certificates described in Subsection (8)(a) shall be of equal dignity and priority without reference to amounts or dates of issue.

(c) (i) A certificate of contribution described in Subsection (8)(a) may be shown by the insurer in its financial statement as an asset in the amount of the certificate of contribution less the amount by which the insurer's premium taxes have already been reduced with respect to the certificate.

(ii) For good cause shown, the commissioner may order the insurer to show a different amount in its financial statement than the amount under Subsection (8)(c)(i).

(9) (a) The association may request information from a member insurer to aid in the exercise of the association's power under this part.

(b) A member insurer shall comply promptly with a request of the association under this Subsection (9).

Amended by Chapter 292, 2010 General Session

31A-28-110. Plan of operation.

(1) (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association.

(b) The plan of operation and any amendments become effective:

(i) upon the commissioner's written approval; or

(ii) after 30 days from the date the plan of operation or amendment is submitted to the commissioner if the commissioner has not disapproved the plan or amendment.

(c) (i) If the association fails to submit a suitable amendment to the plan, the commissioner, after notice and hearing, shall adopt reasonable rules that are necessary or advisable to effectuate the provisions of this part.

(ii) The rules described in Subsection (1)(c)(i) continue in force until:

(A) modified by the commissioner; or

(B) superseded by an amendment to the plan:

(I) submitted by the association; and

(II) approved by the commissioner.

(2) A member insurer shall comply with the plan of operation.

(3) The plan of operation shall, in addition to any other requirement in this part:

(a) establish procedures for handling the assets of the association;

(b) establish the amount and method of reimbursing members of the board of directors under Section 31A-28-107;

(c) establish regular places and times for meetings of the board of directors, including telephone conference calls;

(d) establish procedures for records to be kept of the financial transactions of:

(i) the association;

(ii) the association's agents; and

(iii) the board of directors;

(e) subject to Section 31A-28-107, establish the procedures to be followed for:

(i) selecting members to the board of directors; and

(ii) submitting the selected members to the commissioner for approval;

(f) establish any additional procedures for assessments under Section 31A-28-109;

(g) establish procedures under which a member insurer may be removed from the board of directors for cause, including when the member insurer becomes an impaired or insolvent insurer;

(h) require the board of directors to establish policies and procedures that address conflicts of interests; and

(i) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) (a) The plan of operation may provide that any or all powers and duties of the association, except those under Subsection 31A-28-108(14)(d) and Section 31A-28-109, are delegated to a corporation, association, or other organization that will perform functions similar to those of the association, or its equivalent, in two or more states.

(b) A corporation, association, or organization described in Subsection (4)(a) shall be:

(i) reimbursed for any payments made on behalf of the association; and

(ii) paid for its performance of any function of the association.

(c) A delegation under this Subsection (4):

(i) takes effect only with the approval of:

(A) the board of directors; and

(B) the commissioner; and

(ii) may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this part.

Amended by Chapter 292, 2010 General Session

31A-28-111. Duties and powers under this part.

In addition to the duties and powers enumerated elsewhere in this part, the persons described in this section have the duties and powers described in Subsections (1) through (6).

(1) The commissioner shall:

(a) upon request of the board of directors, provide the association with a statement of the premiums for each member insurer:

(i) in this state; and

(ii) any other appropriate state; and

(b) if an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time.

(2) Notice to the impaired insurer under Subsection (1)(b) constitutes notice to the shareholders of the impaired insurer if the impaired insurer has shareholders.

(3) The failure of the insurer to promptly comply with the commissioner's demand under Subsection (1)(b) does not excuse the association from the performance of its powers and duties under this part.

(4) (a) After notice and hearing, the commissioner may suspend or revoke the certificate of authority to transact insurance in this state of a member insurer not domiciled in this state that fails to:

(i) pay an assessment when due; or

(ii) comply with the plan of operation.

(b) (i) As an alternative to suspending or revoking a certificate of authority under Subsection (4)(a), the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due.

(ii) A forfeiture described in Subsection (4)(b)(i):

(A) may not exceed 5% of the unpaid assessment per month; and

(B) may not be less than $100 per month.

(5) (a) A final action of the board of directors or the association may be appealed to the commissioner by any member insurer if appeal is taken within 60 days of the date the member insurer received notice of the final action being appealed.

(b) If a member insurer is appealing an assessment, the amount assessed shall be:

(i) paid to the association; and

(ii) made available to meet association obligations during the pendency of an appeal.

(c) If the appeal on the assessment described in Subsection (5)(b) is upheld, the amount paid in error or excess shall be returned to the member insurer.

(d) Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(6) The receiver of an impaired insurer shall notify the interested persons of the effect of this part.

Amended by Chapter 292, 2010 General Session

31A-28-112. Reports.

(1) The commissioner shall:

(a) report to the board of directors when:

(i) the commissioner takes an action set forth in Section 31A-27a-201;

(ii) an event described in Section 31A-17-603, 31A-17-604, or 31A-17-605 occurs; or

(iii) the commissioner receives a report from any other commissioner indicating

that an action described in Subsection (1)(a)(i) has been taken in another state;

(b) include in the report to the board of directors required by Subsection (1)(a):

(i) the significant details of the action taken;

(ii) the significant details of an event described in Subsection (1)(a)(ii); or

(iii) the report received from another commissioner;

(c) promptly report to the board of directors when the commissioner has reasonable cause to believe from an examination of any member insurer, whether completed or in process, that the insurer may be an impaired or insolvent insurer; and

(d) furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners.

(2) (a) The board of directors may use the information contained in the ratios and listings described in Subsection (1)(d) in carrying out the board of directors' duties and responsibilities under this part.

(b) The board of directors shall keep the report and the information contained in the ratios and listings confidential until the commissioner or other lawful authority publishes the information.

(3) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(4) (a) The board of directors may make reports and recommendations to the commissioner upon any matter germane to:

(i) the solvency, liquidation, rehabilitation, or conservation of any member insurer; or

(ii) the solvency of any company seeking to do an insurance business in this state.

(b) The reports and recommendations of the board of directors described in Subsection (4)(a) are not public documents.

(5) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(6) The board of directors may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(7) (a) At the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, the board of directors shall prepare a report to the commissioner containing the information the board of directors has in its possession bearing on the history and causes of the insolvency.

(b) In preparing a report on the history and causes of insolvency of a particular insurer, the board of directors may cooperate with:

(i) the board of directors of a guaranty association in another state; or

(ii) an organization described in Subsection 31A-28-108(16).

(c) The board of directors may adopt by reference any report prepared by:

(i) a guaranty association in another state; or

(ii) an organization described in Subsection 31A-28-108(16).

Amended by Chapter 292, 2010 General Session

31A-28-113. Credit for assessments paid.

(1) (a) A member insurer may offset against its premium tax liability to this state an assessment described in Subsection 31A-28-109(2)(b) to the extent of 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid.

(b) To the extent that the offsets described in Subsection (1)(a) exceed premium tax liability, the offsets may be carried forward and used to offset premium tax liability in future years.

(c) If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(2) (a) Money shall be paid by the insurers to the state in a manner required by the State Tax Commission if the money:

(i) is acquired by refund in accordance with Subsection 31A-28-109(6) from the association by member insurers; and

(ii) has been offset against premium taxes as provided in Subsection (1).

(b) The association shall notify the commissioner that the refunds described in Subsection (2)(a) have been made.

Amended by Chapter 342, 2011 General Session

31A-28-114. Miscellaneous provisions.

(1) Nothing in this part shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) (a) The board of directors shall keep a record of a meeting of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 31A-28-108.

(b) A record of the association with respect to an impaired or insolvent insurer may not be disclosed before the earlier of:

(i) the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer;

(ii) the termination of the impairment or insolvency of the insurer; or

(iii) upon the order of a court of competent jurisdiction.

(c) Nothing in this Subsection (2) limits the duty of the association to render a report of its activities under Section 31A-28-115.

(3) (a) For the purpose of carrying out its obligations under this part, the association is considered to be a creditor of an impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Subsection 31A-28-108(14).

(b) Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue the covered policies and pay the contractual obligations of the impaired or insolvent insurer as required by this part.

(c) As used in this Subsection (3), assets attributable to covered policies are that proportion of the assets which the reserves that should have been established for

covered policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) (a) As a creditor of the impaired or insolvent insurer under Subsection (3) and consistent with Section 31A-27a-701, the association and any other similar association are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse the association and any other similar association.

(b) If, within 180 days of a final determination of insolvency of an insurer by the receivership court, the receiver has not made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to the guaranty associations having obligations because of the insolvency, the association is entitled to make application to the receivership court for approval of the association's proposal for disbursement of these assets.

(5) (a) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including:

(i) the association;

(ii) the shareholders;

(iii) policyowners of the insolvent insurer; and

(iv) any other party with a bona fide interest in making an equitable distribution of the ownership rights of the insolvent insurer.

(b) In making a determination under Subsection (5)(a), the court shall consider the welfare of the policyowners of the continuing or successor insurer.

(c) A distribution to any stockholder of an impaired or insolvent insurer may not be made until and unless the total amount of valid claims of the association with interest has been fully recovered by the association for funds expended in carrying out its powers and duties under Section 31A-28-108 with respect to the insurer.

Amended by Chapter 292, 2010 General Session

31A-28-115. Examination of the association -- Annual report.

(1) The association shall be subject to examination and regulation by the commissioner.

(2) The board of directors shall submit to the commissioner each year, not later than 120 days after the association's fiscal year:

(a) a financial report in a form approved by the commissioner; and

(b) a report of its activities during the preceding fiscal year.

(3) At the request of a member insurer, the association shall provide the member insurer with a copy of a report submitted under Subsection (2).

Amended by Chapter 161, 2001 General Session

31A-28-116. Tax exemptions.

The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Repealed and Re-enacted by Chapter 211, 1991 General Session

31A-28-117. Immunity.

(1) For any action or omission committed in the performance of their powers and duties under this part, there is no liability on the part of, and no cause of action of any nature shall arise against:

(a) any member insurer;

(b) a member insurer's agents or employees;

(c) the association;

(d) the association's:

(i) agents or employees; or

(ii) members of the board of directors;

(e) representatives of persons described in Subsections (1)(a) through (d);

(f) the commissioner; or

(g) the commissioner's representatives.

(2) The immunity described in Subsection (1) extends to:

(a) the participation in any organization of one or more other state associations of similar purposes;

(b) an organization described in Subsection (2)(a); and

(c) the agents or employees of an organization described in Subsection (2)(a).

Amended by Chapter 161, 2001 General Session

31A-28-118. Stay of proceedings -- Reopening default judgments.

(1) A proceeding in which the insolvent insurer is a party in any court in this state shall be stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties.

(2) The association may apply to have a judgment under any decision, order, verdict, or finding based on default set aside by the same court that made the judgment. The association shall be permitted to defend against the suit on the merits.

Amended by Chapter 292, 2010 General Session

31A-28-119. Prohibited advertisement of the association -- Notice to owners of policies and contracts.

(1) (a) Except as provided in Subsection (1)(b), a person, including an insurer, agent, or affiliate of an insurer may not make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over a radio station or television station, or in any other way, any advertisement, announcement, or statement written or oral, that uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

(b) Notwithstanding Subsection (1)(a), this section does not apply to:

(i) the association; or

(ii) another entity that does not sell or solicit insurance.

(2) (a) The association shall:

(i) have a summary document describing the general purposes and current limitations of this part that complies with Subsection (3); and

(ii) submit the summary document described in Subsection (2)(a)(i) to the commissioner for approval.

(b) An insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is also delivered to the policy or contract owner before, or at the time of, delivery of the policy or contract.

(c) The summary document shall be available upon request by a policy owner.

(d) The distribution, delivery, or contents or interpretation of the summary document does not guarantee that:

(i) the policy or the contract is covered in the event of the impairment or insolvency of a member insurer; or

(ii) the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer.

(e) The summary document shall be revised by the association as amendments to this part may require.

(f) Failure to receive the summary document as required in Subsection (2)(b) does not give the owner of a policy or contract, certificate holder, or insured any greater rights than those stated in this part.

(3) (a) The summary document described in Subsection (2) shall contain a clear and conspicuous disclaimer on its face.

(b) The commissioner shall, by rule, establish the form and content of the disclaimer described in Subsection (3)(a), except that the disclaimer shall:

(i) state the name and address of:

(A) the association; and

(B) the department;

(ii) prominently warn a policy or contract owner that:

(A) the association may not cover the policy or contract; or

(B) if coverage is available, it is:

(I) subject to substantial limitations and exclusions; and

(II) conditioned on continued residence in the state;

(iii) state the types of policies or contracts for which the association will provide coverage;

(iv) state that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(v) state that the policy or contract owner should not rely on coverage under the association when selecting an insurer;

(vi) explain the rights available and procedures for filing a complaint to allege a violation of this part; and

(vii) provide other information as directed by the commissioner including sources for information about the financial condition of insurers provided that the information:

(A) is not proprietary; and

(B) is subject to disclosure under public records laws.

(4) (a) An insurer or agent may not deliver a policy or contract described in Subsection 31A-28-103(2)(a) and wholly excluded under Subsection 31A-28-103(2)(b)(i) from coverage under this part unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the association.

(b) The commissioner shall by rule specify the form and content of the notice required by Subsection (4)(a).

(5) A member insurer shall retain evidence of compliance with Subsection (2) for the later of:

(a) three years; or

(b) until the conclusion of the next market conduct examination by the department of insurance where the member insurer is domiciled.

Amended by Chapter 292, 2010 General Session

31A-28-120. Prospective application.

Notwithstanding any prior or subsequent law, the provisions of this part that are in effect on the date on which the association first becomes obligated for the policies or contracts of an insolvent or impaired member govern the association's rights and obligations to the policyowners of the insolvent or impaired member.

Amended by Chapter 292, 2010 General Session

31A-28-202. Scope.

This part applies to protect resident policyowners and insureds under all types of direct insurance, except:

(1) life insurance;

(2) annuity;

(3) health insurance;

(4) disability insurance;

(5) mortgage guaranty insurance;

(6) financial guaranty, or other forms of insurance offering protection against investment risks;

(7) fidelity or surety bonds, or any other bonding obligation;

(8) credit insurance;

(9) vendor's single interest insurance;

(10) collateral protection insurance, or any similar insurance protecting the interests of a creditor in a creditor-debtor transaction;

(11) mechanical breakdown insurance, as defined in Section 31A-6a-101;

(12) insurance of a warranty or service contract as defined in Section 31A-6a-101;

(13) title insurance;

(14) ocean marine insurance;

(15) any transaction between a person and an insurer, or an affiliate of a person or insurer, that involves the transfer of investment or credit risk unaccompanied by

transfer of insurance risk; or

(16) any insurance provided by or guaranteed by government.

Amended by Chapter 116, 2001 General Session
Amended by Chapter 363, 2001 General Session

31A-28-203. Definitions.

As used in this part:

(1) "Affiliate" is as defined in Section 31A-1-301.

(2) "Association account" means the Utah Property and Casualty Insurance Guaranty Association Account created by Section 31A-28-205.

(3) (a) "Claimant" means:

(i) an insured making a first-party claim; or

(ii) a person instituting a liability claim.

(b) A person who is an affiliate of the insolvent insurer may not be a claimant.

(4) (a) "Covered claim" means an unpaid claim, including an unpaid claim under a personal lines policy for unearned premiums submitted by a claimant, if:

(i) the claim arises out of the coverage;

(ii) the claim is within the coverage;

(iii) the claim is not in excess of the applicable limits of an insurance policy to which this part applies;

(iv) the insurer who issued the policy becomes an insolvent insurer; and

(v) (A) the claimant or insured is a resident of this state at the time of the insured event; or

(B) the claim is a first-party claim for damage to property that is permanently located in this state.

(b) "Covered claim" does not include:

(i) any amount awarded as punitive or exemplary damages or any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise, nor does it include any supplementary payment obligation, including adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, and bond premiums, prior to the appointment of a liquidator;

(ii) any amount sought as a return of premium under a retrospective rating plan;

(iii) any first-party claim by an insured if:

(A) the insured's net worth exceeds $25,000,000 on December 31 of the year preceding the date the insurer becomes an insolvent insurer; and

(B) the insured's net worth includes the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; or

(iv) any first-party claims by an insured that is an affiliate of the insolvent insurer.

(5) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(6) "Member insurer" means any person who:

(a) writes any kind of insurance to which this part applies under Section 31A-28-202, including the exchange of reciprocal or inter-insurance contracts; and

(b) is licensed to transact insurance in this state.

(7) (a) "Net direct written premiums" means direct gross premiums written in this

state on insurance policies that this part applies to, less return premiums and dividends paid or credited to policyholders on the direct business.

(b) "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(8) "Personal lines policy" means an insurance policy issued to an individual that:

(a) insures a motor vehicle used for personal purposes and not used in trade or business; or

(b) insures a residential dwelling.

(9) "Residence" means, for entities other than a natural person, the state where the principal place of business of a claimant, insured, or policyholder is located at the time of the insured event.

Amended by Chapter 308, 2002 General Session

31A-28-204. Unlawful statements.

(1) It is unlawful to make any statement, written or oral, regarding the coverages and protections provided by the association for the purpose of promoting the purchase of any form of insurance.

(2) It is unlawful to indicate or imply that the association is an agency of the state or that the existence of the association is in any way a guarantee by the state or any of its instrumentalities to insure the payment of claims.

(3) The commissioner shall prescribe rules to prevent:

(a) use of the association as an inducement for the sale of insurance;

(b) the dissemination of false or misleading information regarding the association and its limited guarantees; and

(c) the dissemination of information implying that the association is an agency of the state and that the state in any way insures the payment of claims.

(4) Any person who violates Subsection (1) or (2) is guilty of a class A misdemeanor. Any person who violates a rule under Subsection (3) is liable to the state for a civil penalty of not less than $250 or more than $1,000.

Amended by Chapter 241, 1991 General Session

31A-28-205. Creation of the association.

(1) (a) The Utah Property and Casualty Insurance Guaranty Association shall continue as a nonprofit legal entity.

(b) All member insurers of the association are, and remain, members of the association as a condition of their authority to transact insurance business in this state.

(c) The association shall:

(i) perform its functions under the plan of operation established and approved under Section 31A-28-209; and

(ii) exercise its powers through a board of directors established under Section 31A-28-206.

(d) For the purposes of administration and assessment, the association shall maintain an account known as the Property and Casualty Insurance Guaranty

Association Account.

(e) (i) If as of May 6, 2002, the association has more than one account, the association shall consolidate all accounts into the Property and Casualty Insurance Guaranty Association Account.

(ii) The Property and Casualty Insurance Guaranty Association Account:

(A) succeeds to all funds held by the association in an account existing on May 6, 2002; and

(B) is subject to any liability or obligation attributable to an account of the association existing on May 6, 2002.

(2) (a) An insurer shall cease to be a member insurer on the day following the termination or expiration of the insurer's license to transact the kinds of insurance to which this part applies.

(b) Notwithstanding Subsection (2)(a), the insurer shall remain liable as a member insurer for all obligations, including assessments levied:

(i) before the termination or expiration of the insurer's license; and

(ii) after the termination or expiration of the insurer's license but that relate to an insurer that became an insolvent insurer before the termination or expiration of the insurer's license.

(3) Meetings or records of the association shall be open to the public upon a majority vote of the board of directors of the association.

(4) The association is not an agency of the state.

Amended by Chapter 308, 2002 General Session

31A-28-206. Board of directors.

(1) (a) The board of directors of the association consists of not less than five nor more than nine members, serving terms of four years each.

(b) The members of the board shall be selected by member insurers, subject to the commissioner's approval. When a vacancy occurs in the membership for any reason, the replacement shall be elected for the unexpired term by a majority vote of the remaining board members, subject to the commissioner's approval.

(c) In approving selections or in appointing members to the board, the commissioner shall consider whether all member insurers are fairly represented.

(d) Notwithstanding Subsection (1)(a), the commissioner shall, at the time of election or reelection, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is selected every two years.

(2) A member of the board of directors may be reimbursed from the assets of the association for expenses the member incurs as a member of the board of directors.

Amended by Chapter 363, 2001 General Session

31A-28-207. Powers and duties of the association.

(1) (a) The association is obligated on the amount of the covered claims:

(i) existing prior to the order of liquidation; and

(ii) arising:

(A) within 30 days after the order of liquidation; or

(B) (I) before the policy expiration date if it is less than 30 days after the order of liquidation; or

(II) before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days of the order of liquidation.

(b) The obligation under Subsection (1)(a) includes only that amount of each covered claim that is less than $300,000.

(c) A claim under a personal lines policy for unearned premiums shall include only those claims that exceed $100 in amount, subject to a maximum of $10,000 per policy.

(d) The association shall pay the full amount of any covered claim arising out of a workers' compensation policy. The association is not obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises.

(e) Any obligation of the association to defend an insured on a covered claim shall cease:

(i) upon payment by the association, as part of a settlement releasing the insured; or

(ii) on a judgment, of the lesser of:

(A) the association's covered claim obligation limit; or

(B) the applicable policy limit.

(f) The association:

(i) is considered as the insurer only to the extent of its obligation on the covered claims, subject to the limitations provided in this part;

(ii) has all the rights, duties, and obligations of the insolvent insurer as if the insurer had not yet become insolvent, including the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations; and

(iii) may not be considered the insolvent insurer for any purpose relating to whether the association is subject to personal jurisdiction in the courts of any state.

(g) (i) Notwithstanding any other provisions of this part, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the association to or on behalf of a particular insured and its affiliates on covered claims shall cease when:

(A) a total amount of $10,000,000 has been paid to or on behalf of the insured and its affiliates on covered claims by the association or a similar association; and

(B) all payments on covered claims arise under one or more policies of a single insolvent insurer.

(ii) The association may establish a plan to allocate the amounts payable by the association in a manner the association considers equitable if the association determines that:

(A) there is more than one claimant asserting a covered claim against:

(I) the association;

(II) a similar association; or

(III) a property or casualty insurance security fund in another state; and

(B) all claims arise under the policy or policies of a single insolvent insurer.

(h) The association shall assess member insurers amounts necessary to pay:

(i) the obligations of the association under Subsection (1)(a), as limited by Subsections (1)(e) through (g), subsequent to the liquidation of an insolvent insurer;

(ii) the expenses of handling covered claims subsequent to the liquidation of an insolvent insurer;

(iii) the cost of examinations under Section 31A-28-214; and

(iv) other expenses authorized by this part.

(i) (i) The association shall:

(A) investigate claims brought against the association; and

(B) adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims.

(ii) The association is not bound by a settlement, release, compromise, waiver, or judgment executed or entered into by the insolvent insurer:

(A) less than 12 months before the entry of an order of liquidation; or

(B) more than 12 months before the entry of an order of liquidation if the settlement, release, compromise, waiver, or judgment is:

(I) based on a claim that is not a covered claim; or

(II) the result of fraud, collusion, default, or failure to defend.

(iii) The association may assert all defenses available including defenses applicable to determining and enforcing the association's statutory rights and obligations to a claim.

(iv) The association may appoint and direct legal counsel retained under a liability insurance policy for the defense of a covered claim.

(j) (i) The association shall handle claims through:

(A) its employees;

(B) one or more insurers; or

(C) other persons designated as servicing facilities.

(ii) Designation of a servicing facility is subject to the approval of the commissioner, but this designation may be declined by a member insurer.

(k) The association shall:

(i) reimburse each servicing facility for:

(A) obligations of the association paid by the facility; and

(B) expenses incurred by the facility while handling claims on behalf of the association; and

(ii) pay the other expenses of the association as authorized by this title.

(2) The association may:

(a) employ or retain the persons, including private legal counsel, necessary to handle claims and perform other duties of the association;

(b) borrow funds necessary to implement the purposes of this part in accord with the plan of operation;

(c) sue or be sued;

(d) negotiate and become a party to the contracts necessary to carry out the purpose of this part;

(e) perform any other acts necessary or proper to accomplish the purposes of this chapter; or

(f) refund to the member insurers, in proportion to the contribution of each member insurer to the association account, the amount that the assets of the account

exceed the liabilities, if, at the end of any calendar year, the board of directors finds that:

(i) the assets of the association in the association account exceed the liabilities as estimated by the board of directors for the coming year; and

(ii) the excess assets are not needed for other purposes of this part.

(3) For a refund due to a member insurer for an assessment that has been offset against premium taxes, the association may pay the amount of the refund directly to the State Tax Commission.

(4) The courts of the state shall have exclusive jurisdiction over all actions brought against the association that relate to or arise out of this part.

(5) (a) Any person recovering under this part is considered to have assigned that person's rights under the policy to the association to the extent of that person's recovery from the association.

(b) Every insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent the person would have been required to cooperate with the insolvent insurer.

(c) Except as provided in Subsection (5)(e), the association has no cause of action against the insured of the insolvent insurer for any sums the association has paid out except those causes of action the insolvent insurer would have had if the sums had been paid by the insolvent insurer.

(d) When an insolvent insurer operates on a plan with assessment liability, payments of claims of the association do not reduce the liability for unpaid assessments of the insurer to:

(i) the receiver;

(ii) liquidator; or

(iii) statutory successor.

(e) The association may recover from the following persons the amount of any "covered claim" paid on behalf of that person pursuant to this part:

(i) any insured whose:

(A) net worth on December 31 of the year next preceding the date the insurer becomes insolvent, exceeds $25,000,000; and

(B) liability obligations to other persons are satisfied in whole or in part by payments made under this part; and

(ii) any person:

(A) who is an affiliate of the insolvent insurer; and

(B) whose liability obligations to other persons are satisfied in whole or in part by payments made under this part.

(f) (i) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by:

(A) a determination of a covered claim eligibility under this part; and

(B) a settlement of a covered claim by the association or a similar organization in another state.

(ii) The court having jurisdiction shall grant settled claims a priority equal to that which the claimant would have been entitled to in the absence of this part, against the assets of the insolvent insurer.

(g) The association or any similar organization in another state shall:

(i) be recognized as a claimant in the liquidation of an insolvent insurer for any amounts paid on a covered claim obligation as determined under this part or a similar law in another state; and

(ii) receive dividends or distributions at the priority set forth in Section 31A-27a-701.

(h) (i) The association shall periodically file with the receiver or liquidator of the insolvent insurer:

(A) statements of the covered claims paid by the association; and

(B) estimates of anticipated claims on the association.

(ii) The filing under this Subsection (5)(h) preserves the rights of the association for claims against the assets of the insolvent insurer.

(i) The association need not pay any claim filed after the final date under Sections 31A-27a-406 and 31A-27a-601, or similar statutes of other states, for filing the same type of claim with the liquidator of the insolvent insurer.

Amended by Chapter 309, 2007 General Session

31A-28-208. Assessments.

(1) (a) To provide the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers at the time and in the amount the board finds necessary.

(b) An assessment under this section:

(i) is due not less than 30 days after written notice to the member insurers; and

(ii) accrues interest to the extent unpaid after the due date at the greater of:

(A) 10% per annum; or

(B) the then legal rate of interest provided in Section 15-1-1.

(2) An assessment is to be made in the amount necessary to carry out the powers and duties of the association under Section 31A-28-207 for an insolvent insurer.

(3) An assessment against a member insurer is in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance for which this part applies bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance for which this part applies.

(4) A member insurer may not be assessed in any year for an amount greater than 2% of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance for which this part applies.

(5) If the maximum assessment, together with the other assets of the association in the association account, do not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available.

(6) The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance.

(7) Each member insurer may set off against any assessment authorized

payments made on covered claims and expenses incurred in the payment of the claims by the member insurer, if they are chargeable to the association account.

Amended by Chapter 308, 2002 General Session

31A-28-209. Plan of operation.

(1) (a) The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association.

(b) The plan of operation and amendments described in Subsection (1)(a) are effective upon approval in writing by the commissioner.

(c) Any amendments made under this section after July 1, 1986, shall be made within 180 days of the changed circumstance.

(2) The plan of operation shall continue in force until:

(a) modified by the commissioner; or

(b) superseded by a plan:

(i) submitted by the association; and

(ii) approved by the commissioner.

(3) All member insurers shall comply with the plan of operation.

(4) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(a) establish procedures for handling the assets of the association;

(b) establish the amount and method of reimbursing members of the board of directors under Section 31A-28-206;

(c) establish regular places and times for meetings of the board of directors;

(d) establish procedures for records to be kept of all financial transactions of the association, the association's agents, and the board of directors;

(e) establish the procedures on how selections for the board of directors shall be made and submitted to the commissioner;

(f) establish a procedure for the disposition of dividends or distributions from the estate of the insolvent insurer;

(g) establish any additional procedures for assessments under Section 31A-28-208; and

(h) contain any additional provisions that are necessary or proper for the execution of the powers and duties of the association.

(5) (a) The plan of operation may provide that any or all of the powers and duties of the association, except those under Sections 31A-28-207 and 31A-28-208, are delegated to one of the following that performs functions similar to the association:

(i) a corporation;

(ii) an association; or

(iii) organization other than one described in Subsections (5)(a)(i) and (ii).

(b) A corporation, association, or organization described in Subsection (5)(a) shall:

(i) be reimbursed for any payments made on behalf of the association; and

(ii) be paid for its performance of any function of the association.

(c) A delegation under this Subsection (5) takes effect only with the approval of:

(i) the board of directors; and
(ii) the commissioner.

Amended by Chapter 363, 2001 General Session

31A-28-210. Duties and powers of the commissioner.

(1) In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(a) notify the association of the existence of an insolvent insurer not later than three days after the commissioner receives notice of the order of liquidation; and

(b) upon request of the board of directors, provide the association with a statement of the premiums in this state for each member insurer.

(2) (a) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails:

(i) to pay an assessment when due; or

(ii) to comply with the plan of operation or the rules adopted under this part.

(b) (i) As an alternative to an action described in Subsection (2)(a), the commissioner may levy a fine on any member insurer that fails to pay an assessment when due.

(ii) The fine permitted under this Subsection (2)(b) may not:

(A) exceed 5% of the unpaid assessment per month; or

(B) be less than $100 per month.

(c) The commissioner may revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Any final action or order of the commissioner under this part is subject to judicial review in a court of competent jurisdiction.

Amended by Chapter 363, 2001 General Session

31A-28-212. Credits for assessments paid.

(1) A member insurer may offset against its premium tax liability to this state an assessment described in Section 31A-28-208, but only up to 20% of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liabilities for the year it ceases doing business.

(2) Any sums acquired by a member insurer as a refund from the association which previously had been offset against premium taxes as provided in Subsection (1) shall be paid immediately by the member insurer to the State Tax Commission.

Amended by Chapter 204, 1986 General Session

31A-28-213. Miscellaneous provisions.

(1) (a) Any person who has a claim against an insurer, whether or not the insurer is a member insurer, under any provision in an insurance policy, other than a

policy of an insolvent insurer that is also a covered claim, is required to first exhaust that person's right under that person's policy.

(b) Any amount payable on a covered claim under this part under an insurance policy is reduced by the amount of any recovery under the insurance policy described in Subsection (1)(a).

(c) (i) Except as provided in Subsection (1)(c)(ii) a person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall first seek recovery from the association of the place of residence of the insured.

(ii) If the person's claim is:

(A) a first-party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property; and

(B) a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant.

(iii) Any recovery under this part shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(2) This part may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(3) (a) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out the association's powers and duties under Section 31A-28-207. Records of these negotiations or meetings shall be made public only:

(i) upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the insolvent insurer;

(ii) the termination of the insolvency of the insurer; or

(iii) the order of a court of competent jurisdiction.

(b) This Subsection (3) does not limit the duty of the association to render a report of its activities under Section 31A-28-214.

(4) For the purpose of carrying out its obligations under this part, the association is considered to be a creditor of the insolvent insurer, except to the extent of any amounts the association is entitled as subrogee under Section 31A-28-207.

(5) (a) Before the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including:

(i) the association;

(ii) the shareholders;

(iii) the policyowners of the insolvent insurer; and

(iv) any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer.

(b) In making the determination described in Subsection (5)(a), the court shall consider the welfare of the policyholders of the continuing or successor insurer.

(c) A distribution to stockholders, if any, of an insolvent insurer may not be made until the total amount of valid claims of the association with interest on those claims for funds expended in carrying out its powers and duties under Section 31A-28-207 regarding this insurer have been fully recovered by the association.

(6) A rehabilitator, liquidator, or conservator appointed under any section of this part may recover on behalf of the insurer for excessive distributions paid to affiliates, pursuant to Section 31A-27a-502.

Amended by Chapter 309, 2007 General Session

31A-28-214. Examination of the association -- Annual report.

(1) The association is subject to examination and regulation by the commissioner.

(2) The board of directors shall submit, to the commission by no later than April 30 of each year:

(a) a financial report for the preceding calendar year in a form approved by the commissioner; and

(b) a report of the association's activities during the preceding calendar year.

Amended by Chapter 363, 2001 General Session

31A-28-215. Tax exemptions.

The association is exempt from payment of all fees and taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Enacted by Chapter 242, 1985 General Session

31A-28-217. Immunity.

(1) There is no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his representatives, for any action or omission by them in effecting this part.

(2) The state does not waive any defense under this part, including the defense of governmental immunity. The state is not liable for any action or omission of the association, its members, or their respective agents or employees. The state is not liable for any failure of the association to perform its duties or to fulfill its stated purpose under this part.

Amended by Chapter 97, 1988 General Session

31A-28-218. Stay of proceedings -- Reopening default judgments.

(1) Except for specific cases involving covered claims that are subject to waiver by the association, all proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed until the last day fixed by the court for the filing of claims to permit proper defense by the association of all pending causes of action.

(2) For any covered claim arising from a judgment under any decision, order, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured:

(a) may apply to have the judgment set aside by the issuing court or

administrator; and

(b) shall be permitted to defend against the claim on the merits.

Amended by Chapter 363, 2001 General Session

31A-28-220. Termination of association's operation.

(1) The commissioner shall by order terminate the operation of the association for any kind of insurance covered under this part when the commissioner finds that there is in effect a statutory or voluntary plan that:

(a) is a permanent plan that is adequately funded or where adequate funding is provided; or

(b) extends, or will extend to residents and policyholders, protection and benefits regarding insolvent insurers that are not substantially less favorable and effective to residents and policyholders than the protection and benefits provided regarding the kinds of insurance covered under this part.

(2) (a) The commissioner shall, by the order under Subsection (1), authorize discontinuance of future payments by insurers to the association regarding the kinds of insurance that are the subject of the order.

(b) Notwithstanding Subsection (2)(a), the assessments and payments shall continue, as necessary, to liquidate covered claims of insurers who are adjudged insolvent prior to the order and to pay the related expenses not covered by any other plan.

(3) (a) If the operation of the association is terminated under Subsection (1), the association shall, as soon as possible, distribute the balance of money and assets remaining, after discharging the functions of the association as to prior insurer insolvencies that were not covered by any other plan, together with related expenses, to the insurers that are then writing in this state policies of the kinds of insurance covered by this part, and that had made payments to the association.

(b) The reimbursement described in Subsection (3)(a) shall be:

(i) pro rata; and

(ii) based upon the aggregate of the payments made by the respective insurers during the period of five years next preceding the date of the order.

(c) For a reimbursement of an assessment that has been offset against premium taxes, the association may pay the amount of the reimbursement directly to the State Tax Commission.

(d) Upon completion of the distribution regarding all of the kinds of insurance covered by this part, this part shall terminate.

Amended by Chapter 363, 2001 General Session

31A-28-222. Application of amendments.

(1) The amendments in Laws of Utah 2001, Chapter 363, shall become effective on April 30, 2001 and apply to the association's obligations under policies of insolvent insurers as they exist on or after April 30, 2001.

(2) Notwithstanding Subsection (1), the amendments to Subsections 31A-28-203(3) and 31A-28-207(1)(a) in Laws of Utah 2001, Chapter 363, that add

coverage for unearned premium claims shall apply only to insurers that become insolvent after April 30, 2001.

Amended by Chapter 250, 2008 General Session